

The Medicaid Integration Partnership: An Update

Strengthening community partnerships and improving health outcomes

BRINGING US TOGETHER

The Department of Social and Health Services (DSHS) was created in the 1970s to include seven "administrations," each of them a virtual state department in and of itself. The purpose of the single large state agency was to allow the different social and health service providers to be joined at an operational level to enhance oversight, cooperation and teamwork. In that spirit, DSHS Secretary Dennis Braddock has proposed a new initiative aimed at bridging some of the divisions that have developed over the years. Braddock's charge is for the administrations to reach across the gaps and to create new partnerships that focus squarely on clients and the services they need.

High-risk clients are shared by Medical Assistance, the Mental Health Division, the Division of Alcohol and Substance Abuse, and the Aging and Disability Services Administration. They have an enormous impact on DSHS expenditures:

- ▶ Aged and adult disabled clients comprised 16% of DSHS' 1.3 million clients in FY2001.
- ▶ Medical, mental health, long-term care, and substance abuse treatment for this population accounts for almost one-third of DSHS' budget.
- ▶ Prescription drugs represent one-fifth of all the money DSHS spends on medical, mental health, long-term care and substance abuse treatment services for these clients.

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AND MIP CONTACTS,
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DSHS Secretary Dennis Braddock established the Medicaid Integration Partnership with a memo to his Assistant Secretaries on April 11, 2002. His goals for integration include improving client outcomes, improving cost-effectiveness of services, and improving community partnerships. An intra-agency group launched the Medicaid Integration Partnership (MIP) in May 2002 with the aim of blending funding and integrating services in a major demonstration project during the FY2003-05 biennium.

The Medicaid Integration partners include the Aging and Disability Services Administration, Medical Assistance Administration, Health and Rehabilitative Services Administration, the Office of the Secretary, the Budget office, and Research and Data Analysis Division.

Today, the Secretary's long-range vision is in the initial stages of becoming reality:

Several administrations within DSHS have begun working together on changes to the health-care system that will slow the progression of illness and disability, improve health outcomes, and lower cost of care. The work group has mapped coordinated care arrangements that can integrate Medicaid health care, mental health care, substance abuse treatment, and long-term care benefits. Overall, MIP has taken the first steps toward cost-effective, outcomes-based models that will better manage the needs of Medicaid clients with multiple complex needs.



A timetable for Medicaid Integration:

- ☒ **Fall 2002:** Data and Models workgroups have analyzed the Medicaid population in terms of demographics, use of services, cost of care, and where care is provided. The workgroups also solicited proposals from interested parties and explored care and service delivery for clients who use multiple DSHS services.
- ☐ **May 2003:** Proposals are due to Centers for Medicare and Medicaid Services (CMS) for programs to enroll clients eligible for both Medicare and Medicaid.
- ☐ **August-September 2003:** Announcement regarding CMS dual-eligible program. Based on results, a Request for Proposals (RFP) may seek a business partner for a large-scale demonstration with aged, blind, and disabled clients.
- ☐ **2004:** Implement large-scale demonstration project.
- ☐ **January 2005:** Prepare Medicaid waiver proposal outlining future steps in Medicaid Integration, including full implementation of Medicaid-Medicare integration.

STRATEGIC GOALS FOR MEDICAID INTEGRATION

Four key steps will help achieve the long-range vision of Medicaid Integration:

- ▶ **Design and demonstrate the value of Medicaid integration.** MIP will contract with at least one partner interested in sharing the planning and development costs of a Medicaid Integration Pilot Project.
- ▶ **Implement an integrated health care model that demonstrates effective accountability for health outcomes and promotes Olmstead compliance.** MIP is responsive to the Olmstead imperative to provide "community-integrated" health care and support services that are "medically appropriate" for individuals with disabilities.
- ▶ **Evaluate the demonstration project for its contribution to the longer-range vision.** MIP will evaluate the Medicaid Integration Demonstration Project to assess the impact on service quality, client health & safety and cost-effectiveness.
- ▶ **Employ prudent business practices in Medicaid.** MIP will identify health care integration partners to assist us in delivering the best consumer benefit and public value for our Medicaid expenditures, using sound business and professional practices.

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How Medicaid Integration will work

"I believe the integration of health care and related services is our most consumer-friendly response to the budget crisis we are facing. We must manage the Medicaid program as a strategic enterprise focused on clients with complex medical, long-term care and mental health needs. We can create a comprehensive Medicaid benefit package by designing integrated health-care models that are efficient, effective and accountable. We have an imperative to secure the best value for our public expenditures."

-- Dennis Braddock, DSHS Secretary, November 1, 2002

Key assumptions:

1. **Medicaid comprises the state's most comprehensive benefit package.**
2. **Better management options are available.**
3. **Medicaid savings are possible.**
4. **Integration partners are available.**

An action plan for the Medicaid Integration Partnership:

The partnership's most significant early step will be a major demonstration project involving community partners and thousands of Medicaid clients.

Key portions will include:

- ▶ Identification of health plans who develop partnerships with groups of providers of medical, behavioral, and long-term care in one or two counties.
- ▶ Client population will be at least 4,000 aged and disabled, including dual eligible (Medicare and Medicaid) and mental health clients. Voluntary enrollment will be used pending acceptance of any necessary waiver.
- ▶ Funding streams will be integrated to support a single monthly capitated payment for medical services, prescription drugs, long-term care, behavioral health and other potential elements of care.
- ▶ Research capability at DSHS will be used to explore behavioral health data that can prompt savings in many areas of health care.

Prior to implementation of the major pilot project, there will be other, smaller opportunities to test collaboration between administrations and to look for creative possibilities. These will include:

- ▶ Long-term care work plans to focus on spinal cord injuries and adult day health-adult family home coordination.
- ▶ Medicare eligibility outreach to ensure that clients eligible for Medicare are enrolled promptly, reducing Medicaid expenditures.
- ▶ Third party insurance for children will assist non-custodial parents of children on Medicaid who may qualify for other coverage.

*Executive leadership for the Medicaid project is being provided by **Doug Porter**, the Assistant Secretary for Medical Assistance Administration, and his counterparts at the head of two other DSHS administrations: **Kathy Leitch**, Assistant Secretary/Aging and Disability Services Administration, and **Tim Brown**, Assistant Secretary/Health and Rehabilitative Services. MIP team leaders -- **Alice Lind**, MAA, Team Chair; **Bill Moss**, ADSA; **Cathy Cochran**, Olmstead coordinator; **Corki Hirsch**, DASA; **Darleen Vernon**, MHD; and **Sharon Estee**, RDA -- are coordinating planning and program activities for the pilot and demonstration projects.*

